Appendix B

NHS REFORMS: IMPLICATIONS AND CONSULTATION RESPONSE

Cabinet Member	Councillor Philip Corthorne
Cabinet Portfolio	Social Care, Health and Housing
Officer Contact	Kevin Byrne, Deputy Chief Executive's Office
Papers with report	Annex A – Suggested Consultation Response

HEADLINE INFORMATION

Purpose of report	To inform Cabinet of proposals, consider implications and agree response to Government on NHS reforms.
Contribution to our plans and strategies	Proposals will impact on the Council's relationship with the NHS and offers opportunities for effective partnership and to improve services for residents.
Financial Cost	The proposals do not contain clear details of a financial cost to the Council at this stage.
Relevant Policy Overview Committee	External Services Scrutiny Committee
Ward(s) affected	All

RECOMMENDATION

That the Cabinet Member agrees a response, on behalf of the Council, to the "Liberating the NHS: Increasing democratic legitimacy in health" consultation be sent to the Department of Health as per Annex A.

INFORMATION

Reasons for recommendation

To enable officers to respond by the closing date for consultation of 11 October 2010.

Alternative options considered / risk management

1. Not to respond which would have forgone the opportunity to represent the interests of the Council and residents in the development of proposals.
2. There are opportunities and risks associated with the reforms which are explored further below.

Comments of Policy Overview Committee(s)

The contents of this report have been discussed with the Chairman.

Supporting Information

1. On 12 July 2010, the Secretary of State for Health, Andrew Lansley, set out his vision for the NHS under the Coalition Government through the publication of the Health White Paper "*Equity and Excellence – Liberating the NHS*".

2. In the subsequent 10 days, the White Paper was followed by a raft of four consultations:

- Liberating the NHS: Increasing democratic legitimacy in health
- Transparency in outcomes - a framework for the NHS
- Liberating the NHS: Commissioning for patients
- Liberating the NHS: Regulating healthcare providers

3. The most important of these consultations for local government is "*Increasing Democratic Legitimacy in Health"*. The reforms proposed in the White Paper cover the entire ambit of the NHS' operations, and place new responsibilities on local government. A proposed response to the consultation is at Annex A and more detailed information on the range of NHS reform is set out below.

The Council role

The White Paper sets out the future role expected of councils:

1. **Leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies** - collecting information on our population together with GP consortia in order to design, deliver and purchase the best possible services
2. **Supporting local voice, and the exercise of patient choice** – taking responsibility for the transformation of the local LINk into HealthWatch, and ensuring there are a range of council and health services available
3. **Promoting joined up commissioning of local NHS services, social care and health improvement** – hosting a statutory Health and Wellbeing Board where joined up commissioning plans for the local area are developed
4. **Leading on local health improvement and prevention activity** – with the responsibility for public health passing over from PCTs to councils

Emphasis is also placed on the potential role of place-based budgeting, or "community budgets" which are expected to be a major part of overall Government policy to be announced in the autumn.

These changes are positive and increase the role of councils in the provision of health, which is appropriate given dependencies with Adult Social Care, Children's Services and the ability of Council services to influence the wider determinants of public health.

However, we need to monitor the emerging detail of proposals for GP Commissioning, Joint Commissioning, Integration with Adult Social Care, Children's Services, the Council's Health and Wellbeing Boards, Public Health and HealthWatch to ensure they benefit residents.

Appendix B

Working together with GP Commissioners

The centrepiece of the NHS Reforms is the abolition of 10 Strategic Health Authorities by 2012 and 150 Primary Care Trusts by 2013, in theory releasing an overall management budget reduction of 45% from NHS commissioning.

The reforms will create an independent National Commissioning Board for the NHS. The Board will allocate £80bn in funds to local GP consortia for them to use to commission local health services.

With GPs taking over most of the NHS commissioning budget (apart from some areas delivered directly by the NHS board, e.g, maternity, specialist commissioning and hospital paediatrics), this means the consortia they are part of will purchase the following services for their local area:

- **Acute care** - medical and surgical treatment usually provided by a hospital
- **Secondary care** – specialist care, typically provided in a hospital setting or following referral from a primary or community health professional
- **Primary care** – community health services provided by doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners, practice nurses and allied health professionals
- **Social care** – integrated care for specialist groups, joint commissioning and reablement, potentially provided or funded with the Council

It will be important for local authorities to have a strong working relationship with GP consortia to ensure that commissioning plans for the local area are truly joined up, achieve efficiencies of scale, avoid duplication and meet the needs of local residents.

There are major benefits to closer working between councils and GPs including:

- A clear programme of potential service benefits and financial savings from joint commissioning with the Council and partnership working on public health
- Agreement on evidence and expert needs analysis through the Joint Strategic Needs Assessment (JSNA)
- Giving GPs access to the ways in which the Council and LSP partners exert influence on the wider determinants of health issues
- An improved Council joint commissioning service covering Prevention, Health Promotion, Adult Social Care & Children's Care
- Agreement and plans in place for further joint commissioning with the local health service, including a single vision, set of objectives and outcomes framework
- Places for GPs within the Local Strategic Partnership and Council governance structure. GPs should join the Wellbeing Board, in advance of formation of a statutory "Health and Wellbeing Board"
- There may be potential areas for co-location of social care and health staff working as an integrated team
- Involvement in developing the Council's new public health function

In Hillingdon, the Council is keen to ensure a local flavour is not lost to commissioning and community healthcare provision. It would therefore support a co-terminous GP consortium to achieve better and more efficient partnership working, while also warding off the possible fragmentation in services resulting from the NHS reforms.

Given the strength of existing partnership working, and the major dependencies between Council and health spending, it is also important for the Council to be a part of the drive by existing PCT managers to develop plans for a shadow GP Commissioning Support Vehicle.

Joint Commissioning

The Health White Paper and the "Local Democratic Accountability in Health" consultation paper both fully encourage the extension of joint commissioning: "*The full potential of joint commissioning, for example to secure services that are joined up around the needs of older people or children and families, remains untapped."*

Health and social care are two sides of the same coin, despite broadly being delivered by different sectors with different funding and governance arrangements. It makes sense from a value for money and quality of outcomes perspective for key areas of health and social care to be jointly commissioned and delivered. This helps ensure a seamless service for residents.

Currently, Hillingdon has a Joint Commissioning Team for Adult Services, covering Older People, Carers, Learning Disabilities, People with Physical and Sensory Disabilities, Drugs and Alcohol and Mental Health.

It is in the interest of local residents that this level of joint commissioning continues and is extended, possibly involving pooled budgets to ensure the delivery of value for money and integrated outcomes. This is in line with the proposed role of the statutory Health and Wellbeing Board in the "*Increasing Democratic Legitimacy in Health"* consultation (see Annex A).

Any proposal from existing PCT managers to the Hillingdon GP consortium will have to take account of joint commissioning. It is considered that there is scope for efficiency and more effective working by developing this further into a Council-led service, which would mean not making joint commissioning part of the PCTs commissioning support vehicle "offer" to the GP consortium. The Council would bid to provide the support for joint commissioning directly for GPs, with the commissioning support vehicle picking up the remainder of primary care commissioning. This would assure the continuation of a strong joint commissioning operation and would be consistent with the Council's role in convening the Health and Wellbeing Board, joining up commissioning and leading on the development of the JSNA.

Integrated working with Adult Social Care

In *'Commissioning for Patients'*, it is proposed that GP consortia be under a duty of partnership and that they will be required to demonstrate this by the NHS Commissioning Board. This is potentially helpful development but success will depend on what the primary and secondary legislation stipulates the consortia will have to do in respect of its relationship with the Local Authority and the commissioning of health and health improvement services.

Despite the likely additional statutory powers of the Health and Wellbeing Board, it is evident from the White Paper and the consultation papers alongside it that Health is regarded as the dominant partner in the relationship with Local Authorities when it comes to community health care and social care. These changes show an imbalance of power in the settlement announced by the White Paper. Within this, power has moved to GPs who will become decision-makers for most of the NHS' £80bn commissioning budget.

The ideal solution for residents is joined up or integrated health and social care, to decrease fragmentation and ensure they receive a seamless service. Similarly, more joined up health and social care ensures that in primary and acute settings, clinicians fully involve the local authority in decisions about placements in residential and nursing care.

Current joint commissioning arrangements and integrated services between PCTs and councils are unlikely to be unpicked by GP consortia. The House of Commons Health Select Committee is currently running an inquiry into commissioning to explore this concern. Universally, the White Paper and the Secretary of State for Health's comments have held up integrated working as the solution to better outcomes for service users and greater efficiencies.

Under the proposals, key decisions about the future of older residents – including whether they are able to return to their home, or whether they will need to move into a care home – would be made in a health context, rather than in partnership with social care. Therefore, close alignment with health, including integrated services, is crucial.

Health and Wellbeing Boards

The Government proposes that statutory Health and Wellbeing Boards run by the Council and LSP would have four main functions:

- To assess the needs of the local population and lead the statutory joint strategic needs assessment;
- To promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- To support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and
- To undertake a scrutiny role in relation to major service redesign.

There will be a statutory obligation for the local authority and GPs to participate as members of the Board and act in partnership on these functions.

The White Paper states that membership would be down to individual authorities but *"the boards would bring together local elected representatives including the Leader or the Directly Elected Mayor, social care, NHS commissioners, local government and patient champions around one table. The Directors of Public Health, within the local authority, would also play a critical role. The elected members of the local authority would decide who chaired the board."*

The new Boards would replace current LSP Health Boards and also the Council's Health Overview and Scrutiny function. As such, the Board would be able to:

- call NHS managers to give information, answer questions and provide explanation about services and decisions and making recommendations locally;
- require consultation by the NHS where major changes to health services are proposed; and
- refer contested service changes to the Secretary of State for Health.

In Hillingdon, this effectively represents the conflation of our current LSP Wellbeing Board, chaired by the joint Director of Public Health with the External Services Scrutiny Committee. Putting Health and Wellbeing Boards on a statutory footing is a welcome development. In implementing this it will be important to ensure that:

- the Local Authority's unique democratic mandate through Members to represent local people via the scrutiny role is protected.
- the terms of the duty of partnership must be strong to ensure the Council can fully and properly discharge its role in joining up commissioning for the local area. Although there will be a duty of partnership on GPs, it is unclear what this will entail in practice. Engagement and partnership can be challenging and unappealing areas for clinicians, who perhaps see little benefit from working directly with managers in PCTs or councils.

- In addition, it is important that the timing of the introduction of the Board enables it to work in shadow form so as to be ready to support commissioning of services for Hillingdon residents well before the go live date in 2013. Until that time, the important role of scrutiny through OSC should continue.

Public Health

Subject to Parliamentary Approval, PCT responsibilities for local health improvement will transfer to local authorities, who will employ the Director of Public Health (DPH), jointly appointed with the new, national Public Health Service (PHS).

The DoH will create a ring-fenced public health budget and, within this, local Directors of Public Health will be responsible for health improvement funds. The allocation formula for those funds will include a new “health premium” designed to promote action to improve population-wide health and reduce health inequalities.

The Secretary of State, through the PHS, will agree with local authorities the local application of national health improvement outcomes. It will be for local authorities to determine how best to secure the outcomes.

Funding for health improvement will pass over to the Council from the PCT. It will cover the prevention of ill-health by addressing lifestyle factors such as smoking, alcohol, diet and physical exercise. Broadly, the public health budget will cover prevention, while the NHS budget will cover treatment

Inspection and regulation arrangements for health improvement will be aligned with future arrangements for outcomes in local government, and in particular with the approach to social care outcomes.

The target date is to have the new PHS operational by April 2012. Shadow public health functions will form in councils before then, although shadow public health allocations will not be made until late 2011 for 2012-13, and actual allocations will be made late 2012 for 2013-14. A White Paper on public health is expected in December 2010.

The reforms to integrate public health with councils are to be welcomed, as they will help to drive closer working with health and reflect the fact that Council services have a big effect on wider health determinants for the population. This builds on the work the Council has already begun in Hillingdon with the appointment of a Joint Director of Public Health earlier this year.

In London, it is likely the Mayor will retain certain strategic duties in relation to public health and it is possible certain additional duties and resources will be given to the Mayor. Further detail on this is expected and should be provided within the White Paper.

With public health becoming a Council responsibility, the accountability for the health promotion budget, and hence the overall population health outcomes of the local area will sit with us in future, led by the DPH. As a result, it will be very important to ensure that local GPs and clinicians have played a sufficient part in developing the strategy for health promotion, and that this is strongly linked to the strategy for health treatment (which sits with the NHS), so that there is a single, coherent overall approach to this work for the Borough. If this is not the case, accountability will lie with the Council while some of the tools for delivering improved population health will still lie with the NHS.

As it stands, the arrangements proposed for ensuring a coherent strategy may not be sufficient. While we are able to use the JSNA as the shared process for strategy development with health, this would be bolstered by a proposed additional set of responsibilities:

- A duty for the GP consortium to contribute to the development of the whole population health promotion strategy led by the Council, including a health promotion plan
- A duty for the Council to take into account the view of the GP consortium on the population health outcomes, health promotion and prevention plan

A separate, public health-focused governance arrangement where this work could take place may be necessary, which could report to the Health and Wellbeing Board.

The key requirement for the Council that underpins the transfer of health responsibilities is that the funding for public health is protected during the transition period, over which PCTs are required to make significant financial savings. A formula is being developed by central Government that will be used to calculate the funding allocation that should pass to the Council. This money will be ringfenced following the calculation.

We would recommend to the government that the funding should be allocated to councils in the first instance and not top sliced. Any levy from the Mayor of London on this allocation should take place retrospectively and following a dialogue on the outcomes achieved locally.

Local public involvement - HealthWatch

The consultation states LINks will turn into the local HealthWatch, which will act as local consumer champion across health and social care.

Significantly, LINks will need to scale up and “professionalise” certain functions to discharge their role as HealthWatch. New roles for the organisation include:

- A “Citizen’s Advice Bureau” role for health and social care
- NHS complaints advocacy services
- Supporting individuals to exercise choice, for example helping them choose a GP practice.

This is in addition to the current roles of engaging local people on health and social care issues and giving them a voice, and reporting concerns about the quality of local provision.

Councils will continue to fund HealthWatch and contract for their services. Councils have an important responsibility in holding HealthWatch to account for delivering services that are effective and value for money. All the indications are that a good deal of expectation will be placed on the local HealthWatch to act as the independent consumer champion that helps facilitate choice and competition across local providers.
The consultation paper states that additional funding will be provided to match the additional functions. We would suggest that minimum outcome requirements are set for HealthWatch at a local level, but that councils can make their own judgements about the way of achieving these.

With an increasing role for HealthWatch, a more developed approach to risk management will be required. Clarity is needed regarding who owns the risk attached to the delivery of HealthWatch’s operations, and for example whether a host organisation will be required in future in the way it is now. Councils must be trusted to carry out their own scrutiny, as they do in other areas.

Finally, the consultation paper is silent on whether children's social care is included within the remit of HealthWatch's role – where currently it is not covered by the LINk. This potential, further duty highlights the fact that a measured and scalable approach must be taken for the development of the new HealthWatch. A great number of new functions are being added and voluntary sector capability must be robust to carry these out. A "big bang" approach to introducing this change carries too much risk. It will be important to first establish the right governance and get the finance right, before gradually moving to a broad and effective HealthWatch.

Financial Implications

There are no clear financial consequences emanating from the proposals yet. Further down the line, as proposals are developed, we will need to monitor the implications for Council services.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

Agreeing the consultation response clarifies Hillingdon Council's position and enables officers to engage with the NHS on reforms and seek to influence development locally with NHS Hillingdon and General Practitioners.

It also provides practical input to Government on the implications of the proposals and suggests more effective ways of taking them forward, particularly in regard scrutiny and accountability of health provision.

The Government proposals for the NHS will, potentially, impact on all local residents. Responding to the consultation is the first step in developing Hillingdon Council's response to the opportunities and risks presented.

Consultation Carried Out or Required

None.

CORPORATE IMPLICATIONS

Legal

There are no specific legal implications at this stage. Once the Government introduces legislation to give effect to its proposals, further reports containing detailed Legal Advice will be made to Cabinet.

Relevant Service Groups

The response has been compiled across service groups.

BACKGROUND PAPERS

None.

Appendix B

Annex A

The White Paper team (consultation responses)
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By email: nhswhitepaper@dh.gsi.gov.uk

"Liberating the NHS" Consultation Response from London Borough of Hillingdon

In response to your consultation documents on the Health White Paper "*Equity and Excellence – Liberating the NHS*" , I offer the following views on behalf of the London Borough of Hillingdon on the reforms proposed. In addition, I attach at appendix 1 a direct response to the questions posed for local authorities in the paper *"Liberating the NHS: Increasing democratic legitimacy in health" July 2010.*

Building on Health and Social Care Joint Commissioning

The move to GP led commissioning should take account of the success of joint commissioning between councils and PCTs and seek to build on this. There is scope for efficiency and more effective working by developing this further into a council-led service. This could mean for example, not making joint commissioning part of the PCTs commissioning support vehicle "offer" to the GP consortium. Councils would bid to provide the support for joint commissioning directly for GPs, with any commissioning support vehicle picking up the remainder of primary care commissioning.

The continued success of a strong joint commissioning operation and would be dependent upon a shared vision and integrated working. The "duty of partnership" on GPs is helpful but it must ensure that this happens. It will reinforce the council's role in convening the Health and Wellbeing Board and leading on the development of the JSNA.

Budgets

There is a real concern that the eventual actions to implement commissioning decisions will be diluted due to budgetary pressures and funding being squeezed. It is essential that the residual PCTs are prohibited from asset stripping or designing solutions that do not take into account full costing of patient pathways.

Public Health

With public health becoming a council responsibility it will be very important to ensure that local GPs and clinicians have played a sufficient part in developing the strategy for health promotion, and that this is strongly linked to the strategy for health treatment (which sits with the NHS), so that there is a single, coherent overall approach to this work for the borough. If this is not the case, accountability will lie with the council while some of the tools for delivering improved population health will still lie with the NHS.

The key requirement for the council that underpins the transfer of health responsibilities is that the funding for public health is protected during the transition period, over which PCTs are required to make significant financial savings.

In addition, we understand, that in London, it is likely that the Mayor will retain certain strategic duties in relation to public health. We recommend that the funding should be allocated to councils in the first instance and not top sliced. Any levy from the Mayor on this allocation should take place retrospectively and following a dialogue on the outcomes achieved locally.

Timing of Health and Wellbeing Board

It is important that the introduction of the board enables it to work in shadow form so as to be ready to support commissioning of services for Hillingdon residents well before the go live date in 2013.

Cllr Philip Corthorne
Cabinet Member for Adult Social Care, Health and Housing

Appendix 1

Consultation questions from "Liberating the NHS: Increasing democratic legitimacy in health"

The official consultation response from the London Borough of Hillingdon:

Healthwatch
Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?
Q2 Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?
Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

Hillingdon Response
Q1. HealthWatch must be driven by patient needs and not become preoccupied with bureaucracies surrounding the NHS such as its constitution. Ensuring or overseeing compliance with the constitution feels like a contractual or auditing issue for the NHS rather than a patient voice issue.

Q2. and Q3. A solution needs to be flexible to take account of local needs. Minimum outcome requirements should be set for HealthWatch at a local level and councils left to make their own judgements about the way of achieving these. A measured and scalable approach must be taken for the development of the new HealthWatch. For example, the consultation appears silent on whether children's social care is included within the remit of HealthWatch's role, where currently it is not covered by the LINk. A great number of new functions are being added and voluntary sector capability must be robust to carry these out. A "big bang" approach to introducing this change carries too much risk. We must first establish the right governance and get the finance right, before gradually moving to a broad and effective HealthWatch.

Joint Working and Commissioning
Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?
Q5 What further freedoms and flexibilities would support and incentivise integrated working?
Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Hillingdon Response
Q4,Q5 & Q6. It is evident from the White Paper and the consultation papers alongside it that health is regarded as the dominant partner in the relationship with Local Authorities when it comes to community health care and social care. While councils are strongly reminded that they are not permitted to directly commission health care, the NHS Operating Framework 2010/11 has been altered to permit and encourage health to commission social care services. Similarly the paper proposes the removal of constraints on Foundation Trusts to enable them to augment their role, for example, by expanding into social care.

These changes with others show an imbalance of power in the settlement announced by the White Paper. The ideal solution for patients is joined up or integrated health and social care, to

decrease fragmentation and ensure they receive a seamless service. Similarly, more joined up health and social care ensures that in primary and acute settings, clinicians fully involve the local authority in decisions about placements in residential and nursing care.

The terms of the duty of partnership on GPs must be strong to ensure the council can fully and properly discharge its role in joining up commissioning for the local area. The removal of constraints on health providers needs to be balanced by a compulsion to work with LAs so that efficiencies can be achieved and planning be focused on improving outcomes for patients. Currently, health recommendations can be made without reference to the council, pushing residents into institutional care at great cost to their independence, and at great cost to the council – when a period of council-provided or council-commissioned “reablement” could have averted this. The statutory powers proposed, therefore, are essential and need to go far enough to ensure a shared vision and integrated working.

On Public Health, as it stands the arrangements proposed for ensuring a coherent strategy may not be sufficient. While we are able to use the JSNA as the shared process for strategy development with health, this should be bolstered by a proposed additional set of responsibilities:

- A duty for the GP consortium to contribute to the development of the whole population health promotion strategy led by the council, including a health promotion plan
- A duty for the council to take into account the view of the GP consortium on the population health outcomes, health promotion and prevention plan
- A duty that GP commissioners must involve the local authority in their treatment commissioning plans. This would allow the local authority/public health responsibility for population health outcomes to be discharged. In addition public health advice on needs and discussions on the LA/NHS interface eg hospital discharge planning would be facilitated.

Heath and Wellbeing board

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?

Hillingdon Response

Q7 and Q8. In Hillingdon, the proposals effectively represents the conflation of our current LSP Wellbeing Board, chaired by the joint Director of Public Health with the External Services Scrutiny Committee. Putting Health and Wellbeing Boards on a statutory footing is a welcome development and we would support this. In implementation it will be important to ensure that :

- Local Authority's unique democratic mandate through members to represent local people via the scrutiny role is protected.

- The terms of the duty of partnership must be strong to ensure the council can fully and properly discharge its role in joining up commissioning for the local area.

- In addition it is important that the timing of the introduction of the board enables it to work in shadow form so as to be ready to support commissioning of services for Hillingdon residents well before the go live date in 2013. Until that time the important role of scrutiny through OSC should continue.

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Hillingdon Response

Q9. Not especially. Much of this is in place and working reasonably well. The paper rightly positions the JSNA as the evidence base against which to judge commissioning decisions and review outcomes, an element of compulsion on GPs to commission against clear evidence of need would be helpful.

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

Hillingdon Response

Q10. In Hillingdon the current intention of partners is to continue with the Children and Families Trust arrangements. There is no need to stipulate in legislation clear demarcation between the Children's and the Wellbeing board as these issues are best resolved locally and flexibly. Many of the players and stakeholders would be common to both and it would only require clarity and agreement as to where to sit particular issues to ensure effective outcomes and avoid duplication. We do this at present in a number of subject areas such as crime prevention or community cohesion, for example.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Hillingdon Response

Q11. Governance arrangements and accountabilities should be made as clear as possible. With public health becoming a council responsibility, the accountability for the health promotion budget, and hence the overall population health outcomes of the local area will sit with us the local authority, led by the DPH. We recommend that the funding for public health should be allocated to councils in the first instance and not top sliced. Any levy from the Mayor of London on this allocation should take place retrospectively and following a dialogue on the outcomes achieved locally.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Hillingdon Response

Q12, Q13, Q14, Q15 &Q16. We agree broadly with proposals for membership.

Resolution of disputes would need backing up by clear mandates to challenge and to work collaboratively (see Q7). It is essential that the OSC role is subsumed into the Health and Wellbeing board so as to avoid duplication or worse potentially arrive at conflicting views on the way forward and causing dispute.

LAs should have the flexibility to develop the structure and scope of Health and Wellbeing Boards locally so as to ensure it is able to meet the much broader and challenging remit.

Q17 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?

Hillingdon Response

Q17 Existing public duties and policies on equality provide sufficient protection

Timescales

Q18 Do you have any other comments on this document?

Hillingdon Response

Q18 Clear guidance on timescales is essential. The consultation paper is silent on when the new statutory duty on Health and Wellbeing board would come into force. As with other reforms proposed it is essential to have in operation a shadow arrangement in good time to enable shared approach to GP commissioning priorities before budgets actually transfer. This suggests that on current timing the board needs to be in place at least a year in advance (so April 2012 for GPs taking over in April 2013). In the interim the OSC should continue and the transition be managed so that it is seamless.